FOX CHASE VIRTUA HEALTH
CANCER PROGRAM

NAVIGATION PROGRAM STANDARD OPERATING PROCEDURES

PROCEDURE: Review Referrals

1. Director or other designee as assigned will review patient referrals, both faxed referrals and via navigation database, and assign patient to navigator within 24 hours of referral.

2. Navigator will check fax machine and log onto Navigation database daily to check for new referrals.

3. Patient is now in "active status."

4. At the end of each week, navigator contacts offices to establish check and balance for referrals.

PROCEDURE: Patient Contact

1. Within 24 hours of assignment, navigator will contact patient either by phone or face to face meeting. Navigator may provide information over the phone or schedule a meeting with the patient.

2. When contacting the patient by phone, document in database if a message was left if not able to speak with the patient. Always check physician intake form for permission to leave messages on voicemail.

3. When contact is made with patient:
    a. Introduce yourself and use the Introduction phone script (see Appendix A).
    b. Follow SOP of phone script.
    c. Explain your role.

4. Review binder sections needed at this time:
    a. Address illness, understanding and provide clarification.
    b. Assist patients in understanding their treatment options, and the resources available, including educating eligible patients about appropriate clinical research studies and technologies.
    c. Offer psychosocial support and access to resources.

5. Review physician orders and assist patient as needed.

6. Fill in Navigator Intake form (see attachment B) during initial contact and put information in database.

7. Send Introduction letter to referring physician within 10 days of referral.

8. Once a patient is in the navigation program it is the navigator's responsibility to monitor and follow that patient through the care continuum.

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PROCEDURE: Treatment Planning Conference

1. Coordinate meeting.
2. Prepare patient summary.
3. Access opportunity for clinical trials.
4. Review TX plan against standard of care NCCN guidelines.
5. Document appropriately in database and follow recommendations.
6. Introduction letter sent to referring physician/PCP within 5 business days.

PROCEDURE: Develop Action Plan

1. Review physician orders and assist patient as needed.

2. Include referrals needed, explain referral process and facilitate scheduling appointments if necessary with surgeon, medical oncologist, radiation oncologist, genetic counseling, and other necessary services.

3. Education needed – Understanding of illness
   Emotional impact
   Treatment options
   Approximate time table
   Pre- and post-surgery

4. Provide appropriate resources in a timely manner to meet patient's specific needs, local and national resource list in binder.

5. Provide post procedure/treatment follow-up assessment and education.

6. Put plan in database, including all treatment referrals, appointments, referrals to support services, and barriers to care.

7. Send itinerary to patient (email or hardcopy).

PROCEDURE: On-going Documentation

1. Check daily Task List and document as necessary to keep patient record up-to-date.
2. Contact patient at diagnosis, high stress points, pre- and post-surgery, time of initiation of therapy and any other flag touch point as per navigator task list.
3. Document non-compliance.
4. Document side effects.
5. Document handoffs between disciplines and use handoff script (see Appendix A), if applicable.
6. Monitor treatment plan of care and document treatment.

PROCEDURE: Breast Conference

1. Plan agenda
2. Attend conferences

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PROCEDURE: Handoffs between Disciplines

1. Call appropriate office and use handoff script (see Appendix A).
2. Document handoffs between disciplines in database.

PROCEDURE: Surveillance Plan

1. Contact disciplines and develop surveillance plan for next 6 months post-treatment.

2. Discuss with patient further education and connection to resources.

3. Identify barriers.

4. Email social worker with patient contact information.

5. Within 5 business days of treatment conclusion, letter and surveillance plan sent to referring physician/PCP and cc to patient.

6. Send patient satisfaction survey to patient with surveillance letter.

7. Contact patient to confirm receipt of letter at end of treatment.

8. At end of TX phase have conversation with patient re: change of contact information.

9. At end of treatment phase change patient status to "surveillance" in database.

PROCEDURE: End Service/End of Surveillance (6 months post treatment conclusion)

1. Last contact phone call change patient status to "inactive" in database.

PROCEDURE: Patient Referral at Time of Initial Diagnosis – Internet/Database Connectivity Downtime and Fax Process

Designated Office Staff

1. Upon receiving the completed Physician Intake Form, the office representative will fax the form to the nurse navigator program.
2. Upon fax delivery confirmation, office staff will attach the fax confirmation to the intake form and file in pending nurse navigator referral bin.
3. Navigator program will fax physician office the patient assignment confirmation for office staff to marry to the initial intake referral form.
4. The intake referral packet is filed in patient's medical chart.

Navigators

1. Check fax frequently during downtime procedures.
2. Upon receipt of fax send confirmation to office.
3. Input patient information into database.
4. Make appropriate assignment and contact patient.

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Appendix A

Introduction Phone Call Script

Hello, my name is _____, I am an oncology nurse navigator at the Fox Chase Virtua Health Cancer Program. Dr. _____ has asked me to contact you. My role as a navigator is to guide you through your treatment journey by providing information that will help move you through the health care system. For some women, this is a time of emotional turmoil. I want to tell you about our patient navigation program. I will be your navigator to help you through this time. I will make sure that you get the support and help you need and make sure that you get the best care possible. We can help organize your care and I am here to be a one point of contact for you throughout your journey.

(Ask patient to obtain a pen and paper to write information.)

This is my contact information: Repeat name and spelling, office number, and email.

- Determine what the patient already knows.
- Address illness, understanding, and provide clarification.
- Ask questions about what he or she is worried about?
- Listen to patient and identify immediate needs.
- Establish from patient what appointments have been made.
- Develop follow up plan of care. Establish scheduled appointment dates and help facilitate appointments if needed.

Have you received a *Patient Journey Binder* from your physician?

If YES, proceed to review binder; if NO, set up opportunity to meet patient to provide binder for review.

Additional reasons to instruct patient to call navigator:

1. Keep physician informed
2. Admissions
3. ER visit
4. Change in health status
5. Change in contact information
6. Change of demographic information

Handoff Script

Hello, my name is _____, I am the nurse navigator for the patient _____.
This patient has an appointment for her initial treatment for breast cancer on _____. If you have any questions or concerns, please don't hesitate to call me. I will continue to follow up with the patient throughout her treatment. You can reach me at _____,
Thank you.

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